Cooper/Clayton Program Evaluation Form

Facilitator(s): _____

Class Start Date: _____

Class Location: _____

So we can improve the Cooper Clayton Classes we facilitate, please circle the response that you agree with most using this scale:

1 = very dissatisfied	2 = dissatisfied	3 = satisfied	4 = very satisfied

How satisfied were you with...

1.	comfort level of the room?	1	2	3	4
	comments:				
2.	length of each class?	1	2	3	4
	comments:				
3.	day of the week of the class?	1	2	3	4
	comments:				
4.	time of the day of the class?	1	2	3	4
	comments:				
5.	your facilitator(s)?	1	2	3	4
	comments:				
6.	time allowed for discussion?	1	2	3	4
	comments:				
7.	The class overall?	1	2	3	4
	comments:				

8. After 6 months of being a nonsmoker, would you be interested in being trained to be a Cooper Clayton Method to Stop Smoking Facilitator? If yes, can we please have your name and phone number?

9. Additional comments/suggestions:

Thank you for your time.

We greatly appreciate your responses and comments.

DEPARTMENT OF PUBLIC HEALTH AND WELLNESS

KCP Kentucky Cancer Program

the Cooper Clayton Method to Stop Smoking